

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09476

9482

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deal Island</b>	c. LENGTH OF STAY IN TB <b>all life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deal Island</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Terria</b> Middle <b>Gayvonne</b> Last <b>Bivens</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 31, 1958</b>
9. AGE (In years last birthday) <b>6 month</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b>	IF UNDER 24 HRS. Hours <b>4</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland (hosp.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence Bivens</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Harris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Clarence Bivens</b>		Address <b>- Deal Island, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Found dead in crib</b> <b>921.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Suffocation from milk</b> (c) <b>and bed covers -</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>milk from bottle + bed covers -</b>	
20c. TIME OF INJURY Month, Day, Year <b>5-3</b> Hour <b>8-4</b> p. m. <b>58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Deal Island Somerset Md</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. H. Johnson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. H. Johnson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Aug 8 - 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/5/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>JOHN WESLEY</b>	22d. LOCATION (City, town, or county) (State) <b>DEAL ISLAND MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. B. Webster</b>		24a. REC'D BY REGISTRAR <b>Aug 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Reed</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE  
HEALTH DEPT.

11

Found dead in bed  
No signs of life  
No signs of violence

Male, white, 40 years old

8-8-28 4:40 PM

Dr. H. Johnson  
M.D.

8-8-1928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

9483

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 0233 9-2-58 et

CERTIFICATE OF DEATH

09477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>	
c. LENGTH OF STAY IN 1b <b>51 YRS.</b>		d. STREET ADDRESS <b>NINTH &amp; BROAD STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDDIE</b> Middle <b>VERNON</b> Last <b>COLLINS</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>24</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/18/1907</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months <b>24</b> Days <b>19</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM COLLINS</b>		14. MOTHER'S MAIDEN NAME <b>MISSOURI BROADWATER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MARY TAYLOR</b>		Address <b>MARDN, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxic Myocarditis</b> 322.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Enteritis &amp; Diarrhea</b> DUE TO (c) <b>Chronic Alcoholism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 weeks</b> <b>Several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinsonian Epilepsy</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 1955</b> to <b>Aug. 24, 1958</b> , that I last saw the deceased alive on <b>Aug. 24, 1958</b> , and that death occurred at <b>7:45 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CRISFIELD, MARYLAND</b> DATE SIGNED <b>8/25/58</b>			
ACTUAL SIGNATURE <b>A. N. Barr, M.D.</b>		M.D. <b>CRISFIELD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>A. N. BARR, M.D.</b>		<b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 26, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mariners Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>AUG 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Travis</b>	

CERTIFICATE OF DEATH

Section No.

NAME OF DECEASED [Handwritten: John Brown]		SEX [Handwritten: Male]		AGE [Handwritten: 45]	
DATE OF DEATH [Handwritten: Jan 20, 1928]		TIME OF DEATH [Handwritten: 10:30 AM]		PLACE OF DEATH [Handwritten: Home]	
CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]		PLACE OF BURIAL [Handwritten: St. John's Church]	
SIGNATURE OF PHYSICIAN [Handwritten: J. H. Smith]		SIGNATURE OF MINISTER [Handwritten: W. D. Jones]		SIGNATURE OF CORONER [Handwritten: R. L. White]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Blank]		SIGNATURE OF DECEASED [Blank]	

DECEASED  
 JOHN BROWN  
 DIVISION OF HEALTH  
 BALTIMORE, MD.  
 JAN 20, 1928

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT.  
 IT IS NOT VALID FOR ANY OTHER PURPOSE.  
 THE SIGNATURE OF THE PHYSICIAN IS REQUIRED FOR THE CERTIFICATE TO BE VALID.  
 THE SIGNATURE OF THE MINISTER IS REQUIRED FOR THE CERTIFICATE TO BE VALID.  
 THE SIGNATURE OF THE CORONER IS REQUIRED FOR THE CERTIFICATE TO BE VALID.  
 THE SIGNATURE OF THE DECEASED IS REQUIRED FOR THE CERTIFICATE TO BE VALID.  
 THE SIGNATURE OF THE WITNESS IS REQUIRED FOR THE CERTIFICATE TO BE VALID.  
 THE SIGNATURE OF THE DECEASED IS REQUIRED FOR THE CERTIFICATE TO BE VALID.

**FOR STATE  
HEALTH DEPT.**

9484

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Somerset</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage Grove</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucinda Rudore Cattman</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 13-58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>Christopher Cattman</u>		14. MOTHER'S MAIDEN NAME <u>Corine Viola Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Maggie Smith Westover R.F.D.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crematorily - 7 months -</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>13 hrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		DATE SIGNED <u>August 14-58</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Cottage Grove</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Father - Christopher Cattman</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 18 '58</u>	
ADDRESS <u>Father - Christopher Cattman</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

4000202 XV3

Decedent  
George Brown Jr.  
Residence - Houston, Texas

Age - 38  
Sex - Male  
Date of Death - August 13, 1928

Place of Death - Houston, Texas  
Cause of Death - Myocardial Infarction  
Manner of Death - Natural

Signature of Physician  
R. H. Johnson  
Date - August 14, 1928  
Place - Houston, Texas

9485

## CERTIFICATE OF DEATH

Reg. Dist. No.

09479

1. PLACE OF DEATH o. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WENONA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WENONA</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AT HOME</b>				d. STREET ADDRESS <b>1 MAIN ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>WILLIAM C. DASHIELL</b>				4. DATE OF DEATH <b>August 12 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 11-1876</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>SAMUEL DASHIELL</b>		14. MOTHER'S MAIDEN NAME <b>MELISSA TYLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-01-5336</b>		17. INFORMANT <b>Mrs Della DASHIELL - WENONA</b>		Address <b>Wife MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> (c) <b>Generalized Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>congestive failure</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-10-58</b> , 19____, to <b>8-12-58</b> , 19____, that I last saw the deceased alive on <b>8-12-58</b> , 19____, and that death occurred at <b>10am</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Everett C. Sutter MD</b>				ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b> DATE SIGNED <b>8-12-58</b>			
PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Aug-14-58</b>		22c. NAME OF CEMETERY <b>St. Ann's M.E.</b>		22d. LOCATION (City, town or county) (State) <b>Deal Island Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. S. Webster</b>				24a. REC'D BY REGISTRAR <b>Aug 19 58</b>		24b. REGISTRAR'S SIGNATURE <b>John E. Kiser</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

09480

9486

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Edw. W. McCready Memorial Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Accomack</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Church</b> d. STREET ADDRESS <b>RFD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First Pamela Middle Ann Last Fletcher</b>		4. DATE OF DEATH Month <b>8</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-7-58</b>
9. AGE (In years last birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	IF UNDER 24 HRS. <b>19 58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Leroy Fletcher</b>	
14. MOTHER'S MAIDEN NAME <b>Patsy Ann Ross</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Patsy Fletcher, New Church, Virginia</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature Congenital defect</b> <b>756.2</b> DUE TO <b>Cherry abdominal wall C. Congenital</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>of Bowel</b> DUE TO (c) <b>Congenital defect in Cherry of abdominal wall</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Premature, Bowel normal with Congenital Enlargement of Bowel</b>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Congenital defect of Abdominal wall</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-7</b> , 19 <b>58</b> , to <b>8-8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8-8</b> , 19 <b>58</b> , and that death occurred at <b>10 45</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>George C. Boulton</b> M.D.			
PHYSICIAN'S NAME (Type) <b>George C. Boulton M.D. Jrc</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>8-9-58</b>	<b>Mt. Holly</b>	<b>Accomack, VA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Whistle Williams</b> ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<b>2079161 XV3</b>		DATE <b>AUG 11 '58</b>	<b>Overhain</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9487

09481

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Kingstown</u>		c. LENGTH OF STAY IN 1b hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		2212.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>7 Delaware Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Floyd</u>		First Middle Last <u>Johnson</u>		4. DATE OF DEATH Month Day Year <u>August 3 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1919</u>		9. AGE (in years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>213-14-6244</u>		17. INFORMANT <u>Nettie Johnson - Parsonsburg, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation in Water</u> 9298 DUE TO <u>Drown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Swimming - Went Down Did not Come UP</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>8-3</u> p. m. <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>River</u>		20f. (City or town) (County) (State) <u>Kingston Somerset Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R.H. Johnson</u>		EXAMINER'S NAME (Type) <u>R.H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>August 4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Aug 8 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker Wood</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 3 and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

09482

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHANCE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHANCE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AT HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EARNIE JONES</b>		4. DATE OF DEATH <b>AUGUST 28 1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 22 - 1877</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM KELLY</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE SHORES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>DANIEL JONES - HUSBAND - CHANCE MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO <b>and Hypertensive cardiovascular disease</b> (c) <b>years</b> <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-20-56</b> , 19____, to <b>8-28-58</b> , 19____, that I last saw the deceased alive on <b>8-28-58</b> , 19____, and that death occurred at <b>5:45A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b> DATE SIGNED <b>8-30-58</b>			
ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D.		PHYSICIAN'S NAME (Type) <b>Everett C. Sutter</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CHANCE METHODIST</b>		22d. LOCATION (City, town, or county) (State) <b>CHANCE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. S. Webster</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '58</b>	
ADDRESS <b>Seal Deland Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kious</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

09483

9489

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEAL ISLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEAL ISLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>				d. STREET ADDRESS <u>MAIN ROAD</u>			
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>KELLY</u> Last				4. DATE OF DEATH <u>August 18</u> 19 <u>58</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 25 - 1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>			
11. BIRTHPLACE (State or foreign country) <u>DEAL ISLAND MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILBUR KELLY</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE WEBSTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MRS ELLA KELLY - WIFE</u> Address <u>DEAL ISLAND MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive failure</u> DUE TO (c) <u>Arteriosclerotic heart failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>severe arthritis, cerebral vascular accident 3 yr ago, uremia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (If death occurred in home, give date of injury) <u>bed sores - 3 yr duration, malnutrition severe</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8-15-58</u> , 19 <u>58</u> , to <u>8-18-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-18-58</u> , 19 <u>58</u> , and that death occurred at <u>7p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Everett C. Sutter</u>				M.D. <u>Dames Quarter, Maryland</u> <u>8-18-58</u>			
PHYSICIAN'S NAME (Type) <u>Everett C. Sutter</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 20 1958</u>		<u>ST. JOHNS M.E.</u>		<u>Deal Island Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster - Deal Island</u>				ADDRESS <u>Deal Island Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 22 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9880

<p>1. NAME OF DECEASED                  [Faint text, possibly "John Doe"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>	
<p>3. AGE                  [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH                  [Faint text, possibly "1910-01-01"]</p>	
<p>5. PLACE OF BIRTH                  [Faint text, possibly "Baltimore, Md."]</p>		<p>6. OCCUPATION                  [Faint text, possibly "Teacher"]</p>	
<p>7. MARITAL STATUS                  [Faint text, possibly "Married"]</p>		<p>8. DATE OF MARRIAGE                  [Faint text, possibly "1935-06-15"]</p>	
<p>9. NAME OF SPOUSE                  [Faint text, possibly "Jane Doe"]</p>		<p>10. DATE OF DEATH                  [Faint text, possibly "1955-03-10"]</p>	
<p>11. PLACE OF DEATH                  [Faint text, possibly "Home"]</p>		<p>12. CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>	
<p>13. MEDICAL HISTORY                  [Faint text, possibly "Hypertension, Diabetes"]</p>		<p>14. SIGNATURE OF PHYSICIAN                  [Faint signature]</p>	
<p>15. SIGNATURE OF REGISTRAR                  [Faint signature]</p>		<p>16. DATE OF REGISTRATION                  [Faint text, possibly "1955-03-15"]</p>	

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09484

Reg. Dist. No.

9490

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN lb <b>20 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Enroute to McGready Hospital</b>			d. STREET ADDRESS <b>Box 654, Freemantown, Crisfield</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>RAPHAEL</b> Middle <b>-</b> Last <b>LEMPKINS</b>			4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1913</b>	9. AGE (In years last birthday) <b>45</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crab Picker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Harrison Lempkins</b>		
14. MOTHER'S MAIDEN NAME <b>Odelia ?</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT Address <b>Mrs. Mildred Lempkins, Box 654, Crisfield, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Had coronary attack on Street and died enroute to hospital by car</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Crisfield, Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <b>Wm. H. Coulbourn M.D.</b> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>William H. Coulbourn, M. D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Aug 13/58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/16/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Crisfield, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>AUG 18 '58</b>		
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>					



## CERTIFICATE OF DEATH

Reg. Dist. No.

3491

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>E.W. MCCREADY MEMORIAL HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>F</b> Last <b>NELSON</b>				4. DATE OF DEATH Month <b>8</b> Day <b>12</b> Year <b>19 58</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 1887</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CRISFIELD Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>JOHN H. NELSON</b>			
14. MOTHER'S MAIDEN NAME <b>Betty Lawson</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>XX Yes Wa 5.1</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>CLARENCE NELSON, CRISFIELD, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute intestinal obstruction</b> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma sigmoid</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days - months?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 1958</b> to <b>Aug 1958</b> , that I last saw the deceased alive on <b>8-12-1958</b> , and that death occurred at <b>11:05 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D. <b>CRISFIELD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.</b> <b>CRISFIELD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8/15/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>American Legion</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Hannon</b> ADDRESS <b>Crisfield, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 1 1958</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

9492

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09486

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chance</b> c. LENGTH OF STAY IN 1b <b>76</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chance</b> d. STREET ADDRESS <b>Chance</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Bernice Parks</b>			4. DATE OF DEATH Month Day Year <b>Aug. 12 1958</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <b>Setp. 24n1881</b>		9. AGE (In years lost birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired waterman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Parks</b>			14. MOTHER'S MAIDEN NAME <b>Jeanette Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Ella J. Parks Chance, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x diabetic, Supra Pubic Prostectomy (Prostatectomy)</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>years</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) <b>Chance, Maryland</b>		20g. (County) <b>Chance, Maryland</b>		20h. (State) <b>Chance, Maryland</b>		
21. I certify that I attended the deceased from <b>11-10-55</b> , 19____, to <b>8-12-58</b> , 19____, that I last saw the deceased alive on <b>8-12-58</b> , 19____, and that death occurred at <b>3A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Dumas Quarter, Maryland</b> DATE SIGNED <b>8-14-58</b> ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D. PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8-14-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chance Cemetery</b>		
22d. LOCATION (City, town, or county) <b>Chance, Maryland</b>		22e. (State) <b>Chance, Maryland</b>		22f. (County) <b>Chance, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Wilson</b>		23a. ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 25 '58</b>		
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		24c. (State) <b>Chance, Maryland</b>				



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9494 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

99487

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Fla.</b> b. COUNTY <b>Okeechobee</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Okeechobee</b> ✓	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>48X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Julio Perez</b>		4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Spanish</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4 1937</b>
9. AGE (in years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR: Months <b>1</b> Days <b>15</b> Hours <b>5</b> Min. <b>8</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Farm Work</b>	
12. BIRTHPLACE (State or foreign country) <b>Texas</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. FATHER'S NAME <b>Unknown</b>		15. MOTHER'S MAIDEN NAME <b>Natibidad Perez</b>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Spanish Labor Camp, New Church, Va.</b>		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull, Internal Injuries</b> DUE TO (b) <b>Compound Fracture left forearm</b> DUE TO (c) <b>Multiple Lacerations. Internal Injuries</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>0</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident Princess Anne Somerset Md.</b>	
21a. TIME OF INJURY Month, Day, Year <b>5:15 A.M. 8, 11 58</b>		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway 13</b>		21d. (City or town) (County) (State) <b>Princess Anne Somerset Md.</b>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. H. Johnson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. H. Johnson M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>August 11, 1958</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>Aug. 15, 1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Corpus Christim Texas</b>		23d. LOCATION (City, town, or county) (State)	
24a. FUNERAL DIRECTOR'S SIGNATURE <b>Levin Wilson</b>		ADDRESS <b>Princess Anne, MD.</b>	
24b. REC'D BY REGISTRAR <b>AUG 15 1958</b>		DATE	
24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE	

DEPARTMENT OF HEALTH

PRINCIPAL NAME

ALICE

LABORATORY

UNKNOWN

10

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

9234

DEPARTMENT OF HEALTH

PRINCIPAL NAME

10 3 9

ALICE

LABORATORY

UNKNOWN

Spanish Labor Camp, New Canaan, Va.

Internal injuries

Internal injuries

Internal injuries

Internal injuries

Internal injuries

1044

N. E. Johnson

Aug. 15, 1955

Internal injuries

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09488

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Somerset</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Fla.</u> <span style="float: right;">b. COUNTY <u>Okeechobee</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Okeechobee</u> <span style="float: right;">48X-3</span> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Otilea</u> Middle <u>Otila</u> Last <u>Perez</u>		<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>10</u> Year <u>1958</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Spanish</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>August 30, 1937</u>
<b>9. AGE</b> (In years last birthday) <u>20</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Texas</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Jesus Gonzalez</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Agoda Baskues</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Spanish Labor Camp, New Church, Virginia</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basal fracture Skull, Fracture left</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Orbital Region; Multiple lacerations</u> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident Highway 13</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>3:15</u> <u>8, 11</u> <u>1958</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Highway 13</u>		<b>20f. (City or town)</b> <u>Princess Anne Somerset md.</u> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>R. H. Johnson</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>August 11, 1958</u>	
<b>EXAMINER'S NAME (Type)</b> <u>R. H. Johnson M. D.</u>		<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	
<b>22b. DATE THEREOF</b> <u>Aug. 12, 1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Baptist, Cemetery</u>	
<b>22d. LOCATION (City, town, or county)</b> <u>Pocomoke City, Md.</u> (State)		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Levin B. Kulas</u>	
<b>24a. REC'D BY REGISTRAR</b> <u>AUG 15 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kulas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9495

## CERTIFICATE OF DEATH

09489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Antioch Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARIA</b> Middle <b>AGUSTA</b> Last <b>PORTER</b>				4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 16, 1876</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>John S. Lankford</b>			
14. MOTHER'S MAIDEN NAME <b>Julia W. Corbin</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>---</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mrs Lena L. Porter, Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c) <b>Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>8 yrs.</b> <b>5 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Princess Anne, Maryland</b>				20g. (County) <b>Princess Anne</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>Feb</b> , 1958, to <b>Aug 6</b> , 1958, that I last saw the deceased alive on <b>Aug 6</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>20 Prince William St. Princess Anne, Md.</b> DATE SIGNED <b>8/7/58</b>							
21a. ACTUAL SIGNATURE <b>B. Frank Giganti</b>				21b. PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8-8-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Antioch Methodist</b>	
22d. LOCATION (City, town, or county) <b>Princess Anne, Maryland</b>				22e. (State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>				ADDRESS <b>Pocomoke, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 11 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>							



## CERTIFICATE OF DEATH

Reg. Dist. No.

09490

9496

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>DSSEX</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Princess Anne</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Caldwell</b> 67X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>30 Overlook Road</b>	
3. NAME OF DECEASED (Type or print) <b>Martha V. Pusey</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1867</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Elias Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Martha J. Collins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Dr. Everett Sutter, Dames Quarter, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis, arthritis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <b>8-7-58</b>
21. I certify that I attended the deceased from <b>8-4-58</b> , 19____, to <b>8-7-58</b> , 19____, that I last saw the deceased alive on <b>8-7-58</b> , 19____, and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b> DATE SIGNED <b>8-8-58</b> ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D. PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>8/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Antioch Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Hannon</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 11 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Hannon</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9497

## CERTIFICATE OF DEATH

09491

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>26 Washington Ave.</b>		d. STREET ADDRESS <b>26 Washington Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John</b>		4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>1958</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 11, 1879</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Clara, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Massey Roberts</b>		14. MOTHER'S MAIDEN NAME <b>Olivia White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Mrs. Helen Roberts, Princess Anne, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb</b> , 1956, to <b>Aug 6</b> , 1958, that I last saw the deceased alive on <b>Aug 6</b> , 1958, and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. Frank Giganti</b>		M.D. <b>20 Prince William St</b>	
PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b>		DATE SIGNED <b>8/7/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 8, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Manokin Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin Wilson</b>		24a. REC'D BY REGISTRAR <b>12 1958</b>	
ADDRESS <b>Princess Anne, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krausz</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2 and 3 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		James Henry Roberts	
Sex		Male	
Race		White	
Date of Birth		March 11, 1879	
Place of Birth		U.S.A.	
Usual Residence		38 Washington Ave.	
Cause of Death		Heart Disease	
Date of Death		August 3, 1955	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Official Seal		[Seal]	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1955

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1955

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HEALTH DEPT.

9498

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09492

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>	c. LENGTH OF STAY IN life time	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS <u>Main Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Shores</u>		4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 26, 1913</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Inspection Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tidewater Fisheries</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Shores</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-16-9142</u>	
17. INFORMANT <u>Lottie Shores - wife - Deal Island, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-2-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Deal Island, Maryland (Som. Co.)</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 4 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 10 hours after death.

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>Paula Corcoran Heston</i>		2. SEX <input checked="" type="checkbox"/> FEMALE	
3. AGE <i>38</i>		4. RACE <input checked="" type="checkbox"/> WHITE	
5. DATE OF DEATH <i>Sept 2, 1958</i>		6. TIME OF DEATH <i>11:00 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. OCCASION OF DEATH <i>Heart</i>	
9. DISEASE OR INJURY <i>Heart</i>		10. CAUSE OF DEATH <i>Heart</i>	
11. SIGNATURE OF EXAMINER <i>[Signature]</i>		12. SIGNATURE OF WITNESS <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>	

9499

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>				c. LENGTH OF STAY IN 1b <b>69 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EVY</b> Middle <b>FRANCES</b> Last <b>STERLING</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>26</b> Year <b>19 58</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/4/1889</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HORATIO STERLING</b>				14. MOTHER'S MAIDEN NAME <b>MARY ALLEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>LOIS S. NOONAN, CRISFIELD, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage, hemiplegia, rt.</b> DUE TO <b>Gen'l arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gen'l arterio-sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>19 55</b> to <b>Aug</b> , <b>19 58</b> , that I last saw the deceased alive on <b>Aug. 26</b> , <b>19 58</b> , and that death occurred at <b>10:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D. <b>CRISFIELD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.</b> <b>CRISFIELD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 29, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bradshaw &amp; Sons—Crisfield, Md.</b>				24a. REG. BY REGISTRAR DATE <b>AUG 28 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

2483

Reg. No. 12

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## CERTIFICATE OF DEATH

09494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. Jacksonville Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>FRANK</b> Last <b>WARD</b>		4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 7, 1866</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer and Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming &amp; Seafood</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Ward</b>		14. MOTHER'S MAIDEN NAME <b>Irene Daugherty</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Nellie Ward--2129 N. Calvert St.--Balto., Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 31, 1958</b> , to <b>Aug 3, 1958</b> , that I last saw the deceased alive on <b>Aug 2, 1958</b> , and that death occurred at <b>3:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M.D.</b>		<b>Main St.--Crisfield, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 5, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 8 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2 and fill with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

100

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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the Registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9501

CERTIFICATE OF DEATH

09495

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Somerset</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Marion Station</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Marion Station</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		1	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b>	
(First) <u>Lewis</u> (Middle) <u>Whittington</u> (Last)		(Month) <u>Aug</u> (Day) <u>8</u> (Year) <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 30, 1888</u>
9. AGE last birthday <u>69</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Season</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Marion Station</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Peter Whittington</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-12-0761</u>	
17. INFORMANT & ADDRESS <u>Alverta Whittington Marion, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
151X IMMEDIATE CAUSE (A) <u>Cancer, gastric</u>			<u>2</u>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... <u>8 P</u> .....M, from the causes and on the date stated above.			
SIGNATURE <u>C. Rawley</u>		ADDRESS (Street, city, town, state) <u>Crisfield, Md.</u>	
DATE <u>AUG 18 '58</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/12/58</u>	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	
REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>		LOCATION (City, town, or county) <u>Marion Sta. Md.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Charles H. Neal</u>		<u>Marion Sta. Md.</u>	

# NOTIFICATION

THIS IS TO CERTIFY THAT THE FOLLOWING PERSON HAS BEEN DECEASED AND THAT THE DEATH HAS BEEN REPORTED TO THE LOCAL HEALTH DEPARTMENT. THE DEATH IS BEING REPORTED BY THE PERSON WHO HAS BEEN DESIGNATED AS THE NEXT OF KIN OR THE PERSON WHO HAS BEEN DESIGNATED AS THE PERSON WHO IS RESPONSIBLE FOR THE BURIAL OF THE DECEASED. THE DEATH IS BEING REPORTED TO THE LOCAL HEALTH DEPARTMENT FOR THE PURPOSE OF RECORDING THE DEATH AND FOR THE PURPOSE OF NOTIFYING THE NEARER OF THE DEATH.

## CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

DATE OF DEATH

APPROXIMATE TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF CHILDREN

DATE OF BIRTH OF CHILDREN

NAME OF CHILDREN

DATE OF BIRTH OF CHILDREN

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NAME OF CHILDREN

DATE OF BIRTH OF CHILDREN

9502

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09496

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cristiell</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whites Road - Marion Station</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>McCready Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>William Edward Whittington</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1913</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sea food Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marion Station</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sherman Whittington</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>155-07-678</u>	
17. INFORMANT <u>Sherman Whittington - Marion Sta., Md.</u>		Address <u>Marion Station</u>	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot in right upper chest with pistol</u> 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>caused internal hemorrhage shock.</u> c) stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was on Street at 4th Main when</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>he was shot by a man</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:40 p.m. 8-24-58</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>on 4th St</u>	20f. City or town <u>Cristiell</u>
20g. (County) <u>Somerset</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Wm. H. Coulbourn</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Wm. H. Coulbourn M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Aug 28 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Marion Sta., Som Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ford - Marion Sta., Md.</u>		ADDRESS <u>Marion Station</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

William H. Coulbourn, M.D.  
DEPUTY MEDICAL EXAMINER  
MEDICAL CERTIFICATION  
COUNTY  
2

79

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SP

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1005

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 1927  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*(Faint, mostly illegible handwritten text follows, likely containing patient information, medical history, and cause of death details.)*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09497

Reg. Dist. No.

9503

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>21 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARION STATION</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES HENRY WILLIAMS</b>		4. DATE OF DEATH <b>AUGUST 28 1958</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/1/1915</b>	
9. AGE (In years last birthday) <b>42</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>VIOLA KENNEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>213-185648</b>		16. SOCIAL SECURITY NO. <b>213-185648</b>		17. INFORMANT <b>ADELAIDE WILLIAMS, MARION, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Condition (Embolus)</b> <b>570.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Abdominal Adhesions &amp; Partial Obstruction</b> DUE TO (c) <b>Various Premature myocardial</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 1 1958</b> to <b>Aug 28 1958</b> that I last saw the deceased alive on <b>8-28 1958</b> , and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>MARION STATION, MD.</b>		DATE SIGNED <b>George C. Coulbourn</b>		ACTUAL SIGNATURE <b>George C. Coulbourn</b>		PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN, M.D.</b>		MARION STATION, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG 31-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FAMILY CM</b>		22d. LOCATION (City, town, or county) (State) <b>MARION SOM. MD</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H Ward</b>		ADDRESS <b>marion. Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kross</b>		25. REC'D BY REGISTRAR <b>SEP 4 '58</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kross</b>		26. REC'D BY REGISTRAR <b>SEP 4 '58</b>		26b. REGISTRAR'S SIGNATURE <b>Arthur S. Kross</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1941  
JAN 20  
BALTIMORE

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>M</i>	RACE <i>W</i>	DATE OF BIRTH <i>1900</i>	PLACE OF BIRTH <i>MD</i>
RESIDENCE <i>123 Main St, Baltimore, MD</i>		OCCUPATION <i>Teacher</i>				
DATE OF DEATH <i>Jan 15, 1941</i>		TIME OF DEATH <i>10:30 AM</i>	PLACE OF DEATH <i>Home</i>			
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>				
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>				
DATE <i>Jan 20, 1941</i>		PLACE <i>Baltimore, MD</i>				

FILED JAN 20 1941

100-11111-1000